STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

February 22, 2019

Lynn Ricci, Administrator
Hospital For Special Care
2150 Corbin Avenue
New Britain, CT 06050

Dear Ms. Ricci:

Unannounced visits were made to Hospital For Special Care commencing on January 9, 2018 and concluding on January 16, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a validation survey and a certification inspection.

Attached are the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by March 4, 2019

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the

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violations are not responded to by March 4, 2019 or if a request for a meeting is not made by the stipulated date, the violation(s) shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:lst

CT #'s 23854, 24145, 24069, 24123, 23833

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

1. Based on tour and observations of the Autism unit, the hospital failed to ensure a safe environment when personal hygiene liquids were found in an unlocked and unsupervised room. The findings include:
   a. A tour of the Autism unit (child and adolescent) was conducted on 1/10/19 at 9:30 AM with the Unit Manager and Clinical Coordinator. Patient #11's bedroom door was noted to be open and unattended. In the room, Patient #11 had a supply basket that contained liquid body wash and liquid deodorant. It was identified that the patient had recently taken a shower and the shower supplies were not returned to staff and/or secured and should have been. The unit manager identified that it was the practice on the Autism unit to secure all toiletry products.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

2. Based on tour, observation, interview and policy review the facility failed to ensure for 2 of 8 crash carts that the carts were checked per policy, failed to ensure that expired items were removed from the cart and/or failed to ensure that the emergency equipment (defibrillator) on the emergency cart was checked daily as required by hospital policy. The findings include the following:
   a. Tour of the CMU on 1/9/19 at 9:00 AM identified that the emergency cart supply list was located on the crash cart. The list indicated a line listing of the supplies in the carts and expiration dates if applicable. The list indicated that the cart had been checked by Materials Management in January 2018, March, May and November 2018. Review of the list indicated that the IV started kit expired in May 2018, gloves in August of 2018, blood gas kits in November 2018, an airway in June 2018 and one bad of IV fluids in March 2018.

      Interview with the Nurse Manager on 1/9/18 at 10:00 AM indicated that when nursing checks the emergency cart they are checking the function of the defibrillator and that the crash cart is locked not if the contents are outdated and that is the responsibility of materials management.

   b. Tour of COU on 1/9/19 at 11:00 AM identified that the emergency cart supply list indicated that the supplies had been checked in January of 2018 and September of 2018. Review of COU form on 1/9/19 indicated that four 10 ML prefilled syringes expired in March of 2018, a filter needle expired in March of 2018, pneumothorax kit expired in November of 2018, four pairs of sterile gloves expired in August of 2018, blood gas kits in February of 2018, four airways that expired in May of 2018 through December of 2018, 8 Bags of IV solution, two trachs and electrodes that were expire.

Subsequent to inquiry all the carts in the hospital were checked to ensure outdated supplies were not present. Review of the policy indicated Materials Management is responsible for ensuring that each cart is stocked and maintained. The policy indicated that emergency carts will be checked daily by the nurse and that a detailed inventory of the items will be managed and restocked by materials management. The policy does not identify what the emergency cart checks entail. i.e. checking supply expiration dates.

c. On 01/09/19 9:30 AM, during a tour of the Autism Unit along with the Director of Engineering and Facilities it was observed during a review the emergency cart that the daily logs indicated that the defibrillator was tested daily however review of the testing strip indicated that it was tested on 01/04/19, 01/06/19 and 01/08/19 every other day. Subsequent interview with the Autism Unit Manger and her review of the logs and testing strips confirmed this finding that the testing had not been done daily.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1).

3. Based on observation, interview and policy review the facility failed to ensure for one of three dressing changes observed (Patient #2) that the dressing change was completed per the policy. The finding includes the following:
   a. Observation of Patient #2's Ventricular Assisted Device (VAD) dressing change was completed on 1/9/19 at 9:45 AM. RN #1 was observed to open the sterile pack and place one set of sterile gloves on the window sill and the second set of gloves on the bedside table. RN #1 donned one set of sterile gloves and then donned the second set and indicated this was so he could remove the dirty dressing and then remove the top set of gloves and complete the dressing change.

      RN #1 was observed with two sets of sterile gloves on, remove the patient's dressing, discard the dressing and remove the top set of gloves and then proceed to clean the area. At the conclusion of the dressing change the second set of gloves were removed and discarded.

      Review of the policy directed that staff don sterile gloves and prepare supplies, remove old dressing and discard dressing and gloves, perform hand hygiene and don second pair of sterile gloves.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1).

4. Based on clinical record review and policy review the facility failed to ensure for one of two patient's on the CMU (Patient #27) that vital signs were completed every shift as ordered. The findings include the following:
   a. Review of Patient #27's clinical record with the Nurse Manager on 1/9/19 at 10:30 AM

indicated that the patient had coronary artery bypass in October of 2018 and was admitted on 12/24/18 with congestive heart failure. The physician orders dated 12/24/18 directed vital signs every shift. Review of the record indicated that on 1/3/19 the record failed to reflect that vital signs were completed on the day shift. The record failed to reflect that vital signs were completed on the day shift on 1/4/19 and 1/7/19 or of the evening shift on 1/4/19.

Review of the policy for nursing standards for documentation indicated that the RN is responsible to ensure that data gathered by the team is recorded.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

5. Based on observation the facility failed to ensure for 1 of 2 patients on a tube feeding (Patient #26) that the head of the bed was maintained at 30 degrees. The findings include the following:
   a. Patient #26 was admitted on 12/12/18 with Diabetes, Atrial Fibrillation, a PEG and a wound infection. On 1/10/19 at 1:20 PM of Patient #26 was observed during dressing changes of bilateral lower extremities, identified that patient's tube feeding was placed on hold at the initiation of the dressing change. At 1:45 PM the tube feeding alarmed and RN #2 restarted the infusion of the tube feeding, while the patient remained flat for approximately 15-20 minutes, while the tube feeding was infusing. Review of the care plan 12/13/18 indicated in part that the head of bed elevated at 30 degrees with tube feeding.

   Review of the policy for tube feeding - patient care management protocol indicated to keep the head of bed at 30-45 degree angle or as ordered by the physician when the patient is being tube fed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing service (1).

6. Based on clinical record review, interview and policy review the facility failed to ensure for 2 of 4 patients experiencing pain (Patients #25 and 18) that the patient's pain was assessed and/or reassessed and/or that the clinical record reflected the need for an increased dose of morphine and/or a bolus dose of Versed. The findings include the following:
   a. Patient #25 was readmitted to the facility on 1/7/19 with chronic kidney disease, Diabetes, peripheral vascular disease, coronary artery disease and gangrene of both feet. The physician's order dated 1/7/19 directed hydromorphone 0.5 mg via the G-tube every four hours for a moderate (4-7) pain level. Review of the medication administration record (MAR) with the Unit Manager indicated that on 1/7/19 at 6:20 PM the patient was medicated with Hydromorphone 0.5 mg for a pain level of 6 however the record failed to reflect a reassessment to determine efficacy of the intervention. Patient #25's MAR indicated that on 1/9/19 at 3:30 AM and 11:25 AM hydromorphone 0.5 mg via the G-tube was administered however, the clinical record failed to reflect a pre and/or post assessment of the patient's level of pain.

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b. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the MAR indicated that the physicians order dated 7/12/18 directed Morphine 250 mg in 250 cc's at 10 mg/hr may increase by 2 mg up to a maximum of 20 mg/hour for pain. The physician's order dated 7/19/18 directed MSO4 8 mg IV every 2 hours prn for discomfort.

Review of the IV infusion record indicated that on 7/23/18 at 10:15 AM, 1:35 PM, 6:00 PM and 9:30 PM the patient received 8 mg of Morphine bolus however the clinical record failed to reflect a pain assessment and /or a note for the rationale for the medication.

The infusion record indicated that on 7/27/19 at 2:30 PM and 6:30 PM the patient received an 8 mg bolus and on 7/28/19 at 7:55 AM, 10:00 AM, 5:10 PM and 10:15 PM the patient received 8 mg of Morphine bolus however the clinical record failed to reflect a pain assessment and /or a note for the rationale for the medication.

Interview with the Unit Manger on 1/11/19 at 10:00 AM indicated that pain assessments are completed when The Pain policy indicated that the effectiveness of interventions will be assessed, pain assessments using the pain scale will be done prior to and after all PRN pain medications.

Review of Patient #18's Intravenous Infusion record indicated that on 7/17/18 at 8:55 PM the patient was receiving Morphine 250 mg in 250 cc's at 16 mg per hour. The IV record indicated that at 10:45 PM the Morphine infusion rate was increased to 18 mg per hour however the clinical record failed to reflect a rationale for the change and/or a pain assessment.

Review of Patient #18's physician orders dated 7/16/18 directed Versed 100 mg in 100 cc's IV at 1 mg per hour for seizures and twitching. The 7/19/18 physician order directed 2 mg of Versed IV for seizures every 2 hours as needed. The IV record indicated that on 7/27/18 at 5:10 PM the patient received a 2 mg bolus of Versed. The record failed to reflect the reason for the bolus dose.

Review of the policy indicated that all PRN medications should have documentation of drug, dose, route, date, time reason for administration and effectiveness. The Nursing Documentation policy indicated the nurse administering medications will document the administration on the MAR.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1).

7. Based on clinical record review, interview and policy review the facility failed to ensure for one

patient (Patient #18) that care was provided per the plan of care. The findings include the following:

a. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the care plan dated 7/11/18 indicated that the patient's active problems were in part polypharmacy, psychosocial, nutrition, self-care deficit and skin integrity. Review of the Skin integrity problem indicated that the interventions identified were in part turn and reposition every 2 hours.

Review of the nursing flow sheets for the period of 7/12/18 through 7/29/18 indicated that the patient was turned and repositioned every three hours.

Review of the policy indicated that the care plan contains measureable outcomes and interventions for the patient's medical, surgical, rehab and psychosocial needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

8. Based on observation and interviews during tube feeding administration and/or medication pass it was identified that for 1 of 2 patients (Patient #19) the tube feeding was not administered according to physician orders The findings include:

a. Patient (P) #19 was admitted to the facility with diagnoses that included cervical injury, tracheostomy and gastrostomy tube. According to physician orders dated 12/27/18 P#19 was to receive Neocate Splash unflavored 1 container 6 times a day GT over 1 hour via feeding pump or as a "slow bolus" per patient preference.

During an observation on 1/10/19 at 1:50 PM with Unit Manager (UM) #1 and the Vice President (VP) of Nursing, Licensed Practical Nurse (LPN) #1 was noted to administer one container of Neocate Splash. LPN #1 poured the container of formula into a cup and then withdrew the formula from the cup with a 60 millileter (ml.) syringe, inserted the syringe into the GT and compressed the plunger administering the formula in less than 1 minute. LPN#1 proceeded to repeat the process three times all in the same manner. Upon interview LPN#1 was asked if P#19's tube feeding was able to be administered using gravity to which he/she replied "Yes".

Interview and review of physician order with Unit Manager #1 on 1/10/19 at 2:00 PM indicated the bolus feed P#19 was administered by LPN#1 should have been administered according to physician order (slow bolus) and/or policy and not as a rapid bolus.

Patient Care Management protocol for feeding tubes indicated tube feeding type, amount and rate will be ordered by the physician/APRN in addition policy for tube feed methods identified tube feeding by gravity will usually take 10 to 40 minutes and slight pressure may be used to begin flow then use gravity method.

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9. Based on clinical record review and interview with staff for 1 of 3 patients reviewed for suicide risk screening (Patient #10) the hospital failed to ensure that the screen was accurately completed and/or that a Psychologist or Psychiatrist was notified of the results of the screen. The findings include:
   a. Patient #10 was admitted on 12/31/18 with a diagnosis of Autism. A suicide risk screen dated 12/31/18 identified that the patient had a history of psychiatric treatment. Based on the history of psychiatric treatment, there is a prompt to identify if the patient is in current psychiatric treatment, which was blank. According to the screen, it is required that staff notify a Psychologist or Psychiatrist after completion of the screen. Interview and review of the clinical record with the Clinical Coordinator on 1/10/19 at 11:00 AM identified that there was no evidence that the notification occurred and there was no clinical note by a Psychologist or Psychiatrist.

      In addition, an "environmental check tool-suicide risk" screening is to be completed. Review of the screening tool identified that Patient #10's bed and clothing including pantyhose were removed. Interview with the Clinical Coordinator on 1/10/19 at 11:00 AM identified that the bed was not removed and that items in the screening tool were inaccurate.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records and/or (e) Nursing service (1).

10. Based on clinical record review, and interview the facility failed to ensure that for one of three patient's (Patient #26) with wounds that dressing orders were accurately transcribed. The findings include the following:
    a. Patient #26 was admitted on 12/12/18 with Diabetes, Atrial Fibrillation, a PEG and a wound infection. Review of Patient #26's clinical record indicated that on 1/4/19 the patient had his/her sacral wound debrided. Review of the physician's orders dated 1/4/19 directed wet to dry dressing to the sacrum bid. Review of the treatment record for Patient 26 indicated that the patient's wet to dry dressing was completed once a day for the period of 1/5/19 through 1/10/19.

       Interview with the Nurse Manager on 1/10/19 at 11:00 AM indicated that the order was entered in the computer and was not seen by the staff because the treatment orders should written in the chart. The Unit Manager indicated that the on-call physician must have been aware that not all orders are entered into the computer.

       In addition review of the treatment record indicated that the dressing was not completed on 1/8/19 however the record failed to reflect the reason for the omission.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3).

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11. Based on clinical record review, interview and policy review the facility failed to ensure that for three records reviewed that an accurate clinical record was maintained. The findings include the following:
    a. Review of Patient #26's treatment record with the Manager on 1/10/19 also indicated that the patients tube feeding was held on 1/5/19 and 1/6/19 and the record failed to reflect the rationale. However review of the intake and output record indicated that the tube feeding was administered.

       The policy indicated that all medications that are held will be marked as not done and documentation indicating why it was held will be recorded.

    b. Patient #25 was readmitted to the facility on 1/7/19 with chronic kidney disease, Diabetes, peripheral vascular disease, coronary artery disease and gangrene of both feet. The physician's order dated 1/7/19 directed hydromorphone 0.5 mg via the G-tube every four hours for a moderate (4-7) pain level. Review of the pain assessment form indicated that on 1/8/19 at 5:24 PM and on 1/11/19 at 3:40 AM the patient had an elevated pain level and was medicated with hydromorphone 0.5mg via the G-tube however review of the MAR with the Manager failed to reflect documentation of the medication being administered.

       Review of the policy indicated that the MAR is necessary to keep a record of all medications the patient is receiving. All PRN medications should have documentation of drug, dose, route, date, time reason for administration and effectiveness.

    c. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the care plan dated 7/11/18 indicated that the patient's active problems were in part polypharmacy, psychosocial, nutrition, self-care deficit and skin. The self-care deficit problem indicated that the patient was dependent on staff for all ADL's, patient unable to wash upper body

       Review of the nursing flow sheets with Unit Manger #1 on 1/14/19 at 9:30 AM for the period of 7/12/18 through 7/29/18 indicated that the patient received a bed bath on 7/17/18, 7/18/18, 7/24/28 and 7/25/28 (4 out of 17 days). The Unit Manager indicated that staff should have documented the bath on the flow sheets but she is confident that bed baths were administered.

    d. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the MAR indicated that the physicians order dated 7/12/18 directed morphine 250 mg in 250 cc's at 10 mg/hr may increase by 2 mg up to 20 mg/hour for pain. Review of the MAR indicated that the first bag was hung at 7/13/18 at 6:25 PM. Review of the pharmacy documentation with the Unit Manager indicated that although it was not documented in the clinical record the first bag was hung on 7/12/18 at 4:10 PM.

       Review of the policy indicated that the MAR is necessary to keep a record of all medications the patient is receiving. The Documentation policy indicated that entries

regarding patient care must be completed as close as possible to the time of the occurrence.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and therapeutic facilities and/or (i) General (6).

12. Based on medical record review, review of facility documentation, review of facility policies, observations and interviews for one of two patients reviewed for radiological services (Patient #22 & Patient #23), the facility failed to ensure that lead shielding use during the procedure was documented. The finding includes:
    a. A tour of the Radiology department was conducted on 1/10/19 with Radiology Technician #1 (RT). Observations identified stationary and portable x-ray equipment and multiple lead shielding for the body to include thyroid collars and aprons.

       Patient #22's diagnosis included dysphagia and cerebral ataxia. The out-patient physician's order dated 1/3/19 directed modified barium swallow. The modified barium swallow report identified that the test was performed on 1/9/19 in the radiology department. Review of procedure documentation and interview with RT #1 on 1/10/19 at 2:36 PM indicated that P#22 was protected with a lead apron during the procedure, he could have documented this in the comment section of the procedural notes and did not do so.

       Patient #23 was four years old and diagnosis included seizure disorder. A physician's order dated11/26/18 directed to x-ray of the left 2nd toe for possible fracture. Review of P #23's procedure documentation and interview with RT #1 on 1/10/19 at 3:10 PM noted that the x-ray was performed at bedside, he always utilizes lead shielding on patients and the protection used was not documented.

       Interview with the Regional Radiology Manager on 1/11/19 at 11:09 AM indicated that there was a place in the procedural documentation to answer yes or no for lead protection use for patients who had x-rays and that this had been bypassed for P #22. Further interview identified that the question of whether or not lead protection was used, was not a question that populated in the procedural documentation for patients who had undergone fluoroscopic procedures.

       The facility policy for radiation safety identified a purpose to minimize radiation exposure to staff and patients. The policy further identified that safety measures included shielding.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and therapeutic facilities and/or (i) General (6).

13. Based on observations during tour of the Department of Radiology, The hospital failed to ensure that appropriate signs were posted to ensure safety. The findings include:
    a. On January 16, 2019 as part of the periodic federal Validation Survey, the Radiology Department of the Hospital for Special Care inspection consisted of a review of records,

procedures, equipment and facilities, including the following: (a) in-house physics reports and follow-up corrective actions; (b) personnel dosimetry records; and (c) general safety provisions.

In the Radiology Department, one item of non-compliance was identified within the scope of the inspection.

R.C.S.A 19-24-8 (5)(C) requires in part that each area or room in which sources of ionizing radiation other than radioactive materials are used shall be conspicuously posted with the sign or signs bearing the radiation caution symbol and appropriate wording to designate the nature of the source.

Contrary to the above, the Hospital for Special Care did not have conspicuously posted caution X-Ray signs for some of their diagnostic x-ray rooms or adjacent doors.

On January 16, 2019 the Hospital for Special Care had already completed posting half of the incorrect signage and expected to complete the rest by the COB that day.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

14. Based on a tour of the hospital and staff interview, the hospital failed to ensure that the physical environment was designed and constructed to maintain the safety of patients with suicidal tendencies and/or tendencies to cause harm to themselves or others.
    a. On 01/09/19 at 09:30 AM and various times throughout the day, while touring the autism unit and hospital spaces it was observed that the Patient rooms throughout the Autism Unit and NBU3 lacked institutional fasteners throughout for window and door frames and subsequent interview of the Director of Engineering and Facilities indicated that they should be tamper resistant institutional fasteners.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

15. Based on a tour of the hospital and staff interview the hospital failed to ensure that the physical environment was designed and constructed to maintain the safety of patients with suicidal tendencies and/or tendencies to cause harm to themselves or others.
    a. On 01/09/19 at 10:30 AM, during a tour of the Behavioral Unit 2, the surveyor accompanied by the Vice President of Facility and Facility Staff it was observed that in one patient room the patient's adjustable electric bed had an electrical cord in excess of three (3) feet long and not secured and/or removed to prevent a patient from utilizing them as a means of hanging.

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